Wheeled Mobility Letter of Medical Necessity Form

*INDIVIDUAL'S NAME:	Anna Smith	*ID NUMBER:	000000000

INDIVIDUAL'S INFORMATION AND BACKGROUND						
*1.	**Date of Birth (mm/dd/yyyy):**	0-00-2004				
2.	**Date of Evaluation (mm/dd/yyyy):**	10-01-2013				
*3.	**Address Line 1:**	10 River Street				
	Address Line 2:					
	City:	Wallingford	**State:**	CT	**Zip Code:**	06492

*4.	**Evaluation Location Address L1:**	Green Street School			
	Evaluation Location Address L 2:	123 Main Street			
	Evaluation City:	Wallingford	**Evaluation State:**	CT	**Evaluation Zip Code:**	06492

5.	**Height:**	4 **FT** 1 **IN**	**Weight:**	48 **LBS**	

6.	**Professionals Present:**	**Name**	**Credentials**	**Agency**
		Sylvia Cain	OTR, ATP	Easter Seals of Wallingford
		Mary Brown	MS, PT	Easter Seals of Wallingford
*7.	**DME Provider Evaluator:**	Mr. Wonder Boyd	ATP, CRTS	ABC Mobility Corporation

8.		**Not required for SNF/ICF Residents**		
	Caregiver/Family:	Mr. and Mrs. Patrick Smith	**Present During Evaluation?**	YES

*9.	**Prescribing Physician:**	Kevin Greencrest, MD			
*10.	**Physician Phone Number:**	203-000-0000			
*11.	**Physician Agency:**	Pediatric Medicine Associates, Inc.; Connecticut Hospital			
	Physician Address:	1234 Center Street			
	Physician City:	Meriden	**Physician State:**	CT	**Physician Zip Code:**	06451

12.	**a. Primary Reason for Evaluation:**	Replacement	**b. Primary Issues Relating to DME (explain in 12c):**	■	**Size**
				■	**Does not address current medical needs**
				■	**Does not address current functional needs**
	c. Other Pertinent Information; i.e., additional information from 12b, rationale for replacement vs. modification, repair history, other information regarding request:	Child's current power chair does not address her needs in numerous ways: (1) seating frame is too small and unable to be grown without replacing seat frame; (2) seating does not adequately address postural, orthopedic, or tonal deficits despite multiple modifications; (3) mobility base design impedes ADL access since tilt regulation does not dissociate from seat elevator height. [As the seat height is raised, the frame tilts which prevents her independence for ADL tasks; e.g., sink, tables, desks.]; and [4] speed regulation does not dissociate from seat height regulation.		

*13.	**General Description of DME Recommendation:**	Quantum Q6 Edge with power tilt, power seat height, and seating components

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14.	DIAGNOSIS(ES), INCLUDING RECENT SURGERIES AND DATES OF SURGERIES	RECENT CHANGE IN MEDICAL STATUS
	Cerebral Palsy w/ resultant spastic diplegia (R side weaker than L side); Hx Periventricular Leukomalacia and infantile seizures; estropia surgically corrected at 1 yr/old	NO
	Baclofen pump insertion July 2011	NO

14a.	Explain recent change in medical condition and/or other relevant information including symptoms, treatments, interventions and medications:	She presents with estropia in which misalignment of her eyes is observed when one eye medially deviates while the other eye fixates normally. When both eyes are aligned/aimed at the same visual target, she is able to see one target. When one eye turns medially, this decreases her depth perception & binocular visual skills. Although Anna had corrective surgery, residual deficits persist: visual tracking deficits in lower quadrants below [see #17]

15.	How will the person's anticipated medical changes be accommodated in the requested Wheeled Mobility Device?	■	The requested Wheeled Mobility Device can be modified to meet anticipated medical needs
		■	Other:
			The power chair seating frame and seating components allows for adequate growth and can be adapted seating components to address changes in her orthopedic status.

16. Caretaker Support: ☐ The individual has 24 Hour Care.

16a.	Caretaker Support Hours per Day:	> 10 hours	Relationship/Role:	family and school paraeducator
16b.	Amount of Time Alone per Day:	> 10 hours		

17. Additional Information:

[continued from 14a]

horizontal level & difficulty viewing objects in right visual field. She compensates by turning her head to the right & looking down.

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***18. List all Current/Previous DME:**

DME TYPE, INCLUDING MANUFACTURER AND MODEL	DATE OF PURCHASE (MM/YYYY)	ENVIRONMENTS WHERE USED (SELECT ALL THAT APPLY)	IS DME CURRENTLY BEING USED?	IF INEFFECTIVE, PROVIDE REASON	SKILL LEVEL (CHECK ALL THAT APPLY)
18A. Type/Mfg/Model:	(MM/YY)	☐ Home	Yes	Although this was intended for home use, she is unable to use at home.	■ Independent
Power chair	09/12	☐ Work			☐ WNL endurance and distance
Permobil Koala w/ power tilt, seat elevator, attendant control, and standard Permobil seating		■ School			☐ Below normal endurance and distance
		☐ Community			☐ Dependent
		☐ SNF/ICF			■ Other: limits ADL independence
Comments, including special features (e.g., specialty seating components or electronics):	This therapist & ABC Rehab technician modified the seating & electronic settings to optimize her positioning & function (13.5 hrs) using donated components. Despite these efforts: [1] seating frame is too small & requires a new seat frame; [2] seating components do not adequately address her postural, orthopedic, & tonal deficits and increases her posterior pelvic tilt & lateral thoracic leaning; and (see #37)				
Ownership:	☑ Personally Owned		☐ Other		
18B. Type/Mfg/Model:	(MM/YY)	■ Home	Yes		☐ Independent
Medical scooter	04/12	☐ Work			☐ WNL endurance and distance
Convaid Clipper		☐ School			☐ Below normal endurance and distance
		■ Community			■ Dependent
		☐ SNF/ICF			☐ Other:
Comments, including special features (e.g., specialty seating components or electronics):	used for passive mobility				
Ownership:	☑ Personally Owned		☐ Other		
18C. Type/Mfg/Model:	(MM/YY)	■ Home	Yes		☐ Independent
Prone Stander	03/10	☐ Work			☐ WNL endurance and distance
Prospect Designs Alicia		☐ School			☐ Below normal endurance and distance
		☐ Community			■ Dependent
		☐ SNF/ICF			☐ Other:
Comments, including special features (e.g., specialty seating components or electronics):	includes lateral trunk/hip supports, posterior gait, tray, and shoe holders A different Alicia prone stander is also used at school.				
Ownership:	☑ Personally Owned		☐ Other		
18D. Type/Mfg/Model:	(MM/YY)	■ Home	Yes		☐ Independent
Gait Trainer	05/12	☐ Work			☐ WNL endurance and distance
Up N Go Easy Walking		☐ School			☐ Below normal endurance and distance
		☐ Community			☐ Dependent
		☐ SNF/ICF			☐ Other:
Comments, including special features (e.g., specialty seating components or electronics):	Used for ambulation training; able to ambulate short distances with adult physical assistance and guidance/supervision				
Ownership:	☑ Personally Owned		☐ Other		

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19. Functional Skills

ACTIVITY	LEVEL OF INDEPENDENCE	DME USED TO ADDRESS FUNCTIONAL TASK		COMMMENTS/FUNCTIONAL CONSIDERATIONS FOR REQUESTED DME
Bathing	Maximal assistance	Provide number from DME list on page 3:		Rifton Blue Wave Bath chair with stand (not listed on p. 3) Attempts to use soap
Dressing	Dependent	Provide number from DME list on page 3:		
Grooming	Dependent	Provide number from DME list on page 3:		
Eating	Maximal assistance	Provide number from DME list on page 3:		Independent drinking from closed cup yet needs assistance graduating liquids; uses built-up angled spoon
Toileting	Maximal assistance	Provide number from DME list on page 3:		OTC potty cover/ring reducer; Maximal assistance perineal care and clothing management
In-home mobility	Dependent	Provide number from DME list on page 3:	18b	uses gait trainer w/ max assistance or scoots/commando crawls or carried by adults

20. Orthosis(es)/Prosthesis(es): ☐ **NA / None**

ITEM	LEFT/RIGHT/BOTH	EFFECTIVENESS	COMMENTS/IF INEFFECTIVE, PLEASE EXPLAIN
Knee-Ankle-Foot Orthosis(es)	Both	Effective	Includes Left foot shoe buildup for leg length discrepancy
None	N/A	N/A	
None	N/A	N/A	
None	N/A	N/A	
None	N/A	N/A	

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21. Transfer skills: ○ Independent for all transfers ◉ Dependent for all transfers ○ Varied transfer skills; see completed table

FROM	TO	METHOD	LEVEL OF INDEPENDENCE	EQUIPMENT
Bed	Wheeled mobility device	1 person lift	Maximal assistance	None
Wheeled mobility device	Stander	1-2 person lift	Dependent	None
When carried	Bathtub	1-2 person lift	Dependent	None
Floor	Wheeled mobility device	1-2 person lift	Dependent	None

22. Ambulation skills: ○ Non-ambulatory on all surfaces ○ Ambulatory on all surfaces ◉ Varied ambulation skills; see completed table

SURFACE	AMBULATION STATUS	SPEED	DISTANCE	ENDURANCE	BALANCE	SPECIFY AMBULATION AIDE
Carpet:	Non-Ambulatory	N/A	N/A	N/A	N/A	N/A
Smooth:	Ambulatory	Slow	< 10 Feet	5 - 10 Minutes	Severe Impairment	gait trainer
Varied Terrain:	Non-Ambulatory	N/A	N/A	N/A	N/A	N/A
Stairs:	Non-Ambulatory	N/A	N/A	N/A	N/A	N/A

23. Describe conditions which impact person's ability to ambulate and/or transfer safely, independently, and in a timely manner; e.g., weakness, cardiovascular/respiratory compromise, range of motion deficits, imbalance, tone, cognitive deficits, coordination, sensory deficits:

Ambulation and transfers are difficult due to global weakness, tonal influences (trunk/core hypotonia and upper/lower extremities spasticity), and associated balance limitations.

24. Postural Control, Muscle Strength, and tone (Medical Research Council [MRC] Scale for Muscle Strength)

	STRENGTH	(+) / (-)	TONE	COMMENTS
Trunk:	Fair (3)	(+)	Hypotonia/Flaccid	
Right Upper Extremity:	Poor (2)	(+)	Spasticity	
Left Upper Extremity:	Fair (3)	(+)	Mixed Tone	needs B UE support to optimize fine-motor skills
Right Lower Extremity:	Poor (2)		Spasticity	
Left Lower Extremity:	Poor (2)	(+)	Spasticity	
Head/neck:	Fair (3)	(+)	Mixed Tone	influenced by trunk and B UE support/alignment

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25. Postural Alignment of trunk, pelvis, neck, and lower extremities

	POSTURAL ALIGNMENT	FIXED VS. FLEXIBLE	COMMENTS, INCLUDING QUANTITATIVE DATA
Trunk/Spine:	Scoliosis	Flexible	left trunk leaning/rotation and anterior trunk flexion
Pelvis/Hips:	Pelvic Obliquity lower on left	Flexible	
Head/Neck:	Mixed	Flexible	see "Other Pertinent Information"
Leg Length:	Discrepancy	Fixed	left LE 1/2" shorter than right LE
Ankles/Foot/Toes:	Even	Fixed	AFOs help maintain ROM and address spasticity
Other pertinent information:	head/neck position varies between hyperextension/flexion & neck tilt w/ rotation and lateral tilt to left		

26. Coordination, Motor Control, and Balance

ACTIVITY	FUNCTIONAL SKILLS	ACTIVITY	COMMENTS/FUNCTIONAL SKILLS
Sitting Balance (Static):	Leans or slides	Standing (Static):	Unsteady
Describe:	L lateral trunk leaning w/ rotation	Describe:	requires external adult support or gait trainer
Upper Extremity Gross Motor Control:	L UE- limited active movement	Upper Extremity Fine Motor Control:	L hand- poor/trace active movement
Describe:	R UE- mild impairment	Describe:	R hand Displays WNL fine-motor skills

27. Range of Motion (Optional: attach data)

AREA AFFECTED	RANGE OF MOTION LIMITATIONS RELATIVE TO SEATING	COMMENTS/QUALIFYING INFORMATION
Right Upper Extremity:	-20 shoulder flexion and abduction	
Left Upper Extremity:	moderate flexion deficits in L UE fingers, wrist, elbow	ROM influenced by spasticity; impacts joystick reach
Right Lower Extremity:		AFOs &angled footplates maintain full ROM
Left Lower Extremity:		
Head/Neck:		neck position impacted by visual deficits and hip/trunk

28. Pain (Ref: www.painmed.org/SOPResources/ClinicalTools/government-websites/). ☐ **Unable to determine if person is experiencing pain**

LOCATION	INTENSITY	FREQUENCY	DURATION	COMMENTS/QUALIFYING INFORMATION; RELATIONSHIP TO POSITIONING
None	N/A	N/A	N/A	verbal with no apparent pain
None	N/A	N/A	N/A	verbal with no apparent pain
None	N/A	N/A	N/A	verbal with no apparent pain

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29. Skin integrity (optional: attach Braden Scale http://www.bradenscale.com/images/bradenscale.pdf)

CURRENT SKIN INTEGRITY STATUS		HISTORY OF SKIN INTEGRITY		RISK FACTORS	
Intact		Intact		☐	None
If Impaired, date(s) of onset:		If Impaired, date(s) of onset:		☐	Impaired Nutritional Status
If Impaired, stage:		If Impaired, stage:		■	Bony Prominences
If Impaired, location(s):		If Impaired, location(s):		☐	Fecal and/or Urinary Incontinence
Ability to use pressure reducing methods:		Self-positioning		☐	Circulatory Compromise
Pressure Methods Comments:				■	Immobility
				☐	Sensory Deficits
				☐	Aged Skin
General Comments: Anna uses: [1] tilt in space feature in power chair throughout school day; [2] stander at home and school; [3] donated/borrowed tilt in space manual wheelchair at school which does not promote posterior pelvic tilt position; and [4] gait trainer at home.				If Sensory Deficits, indicate:	

30. Cardiovascular, Pulmonary, Vascular, Bowel and Bladder status

	CONDITION	CLINICAL OBSERVATIONS / REFERENCE TO DIAGNOSIS
Cardiac Status:	Normal	
Pulmonary Status:	Normal	
Vascular Status:	Normal	
If Impaired, Edema Grade Level:	N/A	
Bowel and Bladder Status:	Normal	
Catheterization:	No	
Suppository use:	No	

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31. List the primary medical and functional objectives for the recommended wheeled mobility device, including how this will impact the individual's ADL independence:

The current power chair prevents ADL access due to lack of dissociation between tilt & seat elevation regulation & joystick mounting hardware design which impedes independent access to sink or table. The proposed power chair includes a retractable joystick mount & dissociated seat tilt & seat height regulation, which allows access to sinks, tables, & desks for hygiene, eating, & tabletop task independence. Therefore, the seat height will not influence the seat tilt & the seat tilt will not influence the seat height. She will also be able to use a power chair at home and across all customary environments.

32. Describe the effectiveness of the trial simulation(s), including the person's ability to utilize the recommended wheeled mobility device system within their customary environment(s), i.e., hallways, bedroom, bathroom, ramp, varied terrain. The following criteria/information must be included reflecting the person's cognitive, visual, safety, and fine and gross motor skills: (1) strength (2) endurance (3) range of motion (4) balance (5) risk factors considered, e.g., repetitive motion (6) location of trials (7) duration/frequency of trial(s) (8) ability to use controls; e.g., directionality, start/stop, special features; i.e., tilt, recline, power leg rests, seat elevator, power assist, one arm drive, tiller (9) need for additional training or caretaker assistance for drive controls. Indicate Dependent if applicable.

As demonstrated by her power chair experience at school since 09/2011, she is able to safely navigate in large spaces & small areas; e.g., hallways, bathroom, doorways, small classroom spaces, outside varied terrain. She demonstrates adequate cognitive & visual skills to safely navigate even with many adults/children present. Risk factors associated with Estropia are compensated by distance adult supervision, her intrinsic cautiousness & with proposed upright visual display. Bumpers suggested to deter hitting boundaries which will be highlighted using a bright color (yellow). She demonstrates excellent directionality sense, start/stop, yet needs assistance when to tilt seat frame and elevate the seat. Additional training will be provided by OT/PT regarding the new power chair controls and use of the power tilt and seat elevation.

33. Are there anticipated changes in the individual's customary environments with the next 1-2 years? If so, how was this taken into consideration for the requested wheeled mobility device?

◉ **No** ○ **Yes, please explain:**

34. Explain/describe other medical approaches, functional strategies, other DME and/or alternative treatment(s), which were considered and ruled out in lieu of using a wheeled mobility device.

No other medical approaches or strategies were considered for functional independent mobility. Anna requires a power chair for independent mobility across all of her customary environments for mobility-related activities of daily living since she is unable to ambulate mid or long distances with a gait trainer.

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35. For residents of Skilled Nursing Facilities:

a. What is the length of time per day that the wheeled mobility device will be used?	
If this request is for a replacement wheeled mobility device under Sec. 17-134d-46 Customized Wheelchairs In Nursing Facilities Regulation, attach a copy of the current positioning program (required).	
b. Describe the positioning program used to address the individual's needs, including the monitoring program.	
c. What is the person's out of bed tolerance?	

36. Training to be provided to who/where/by whom for wheeled mobility use:

CLINICAL OBSERVATIONS / REFERENCE TO DIAGNOSIS
Request is for replacement Wheeled Mobility Device; therefore, the member has demonstrated proficient wheeled mobility skills
If other, please explain: Additional training will be provided by OT/PT regarding the new power chair controls and use of the power tilt and seat elevation.

37. Comments (include e. g., Continued from #xx):

(Continued from #18A)

[3] frame & electronics impede ADL access and independence since the tilt regulation does not dissociate from the seat height regulation.

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Based on the clinical assessment & consideration of various Wheeled Mobility options, the following is suggested to address this person's medical needs:

38.	∗ Description of DME component: This list can be pre-populated by the DME Provider. Postural components can be combined with hardware; e.g., lateral trunk pads with swing-away mounting hardware; phenolic upper extremity support with channel locks and strap.	39. **Medical Rationale: Pre-populated, generic, and general rationales and definitions will not be accepted. Information must include:** ▪ Document the rationale for requested base or component for this specific person, as correlated with the documented clinical information. Reference comparisons and simulations; e.g., "Based upon trials of the seat cushions xx, yy, and zz, the zz cushion was chosen because…." Note: Only the essential components require comparison of various options, as related to the person's medical condition. ▪ If appropriate, include reason why a standard component would not address the person's medical needs. ∗ **Technical rationales can be written by the DME provider which should be designated with an asterisk**. Include the reason the component is needed, as compared to less complex alternatives and correlated with necessary functional or technical outcomes.
a.	Quantum Q6 Edge 3SP-SS power chair	(1)provide independent mobility across all customary environments (2)provide mid wheel drive for home access & other small turning radius areas (3)chosen due to need for visual display for multiple control modes (4)includes transit option to ensure transportation safety due to spasticity & limited protective responses
b.		(5) Permobil C-300 and Sunrise Medical QM-710 considered but recommended seat width and seat height not available
c.	Power elevating seat 6"	to allow excursion for access and to optimize her ADL independence (hygiene, eating, toilet, all tabletop tasks) while promoting adequate functional height to transfers in/out of the power chair to gait trainer, bed, stander, and bathtub.
d.	Controller, Joystick Mod Qlogic w/ LCD Display; Enhanced Display Kit	(1) to allow Anna to view the content of the controller for mode control & change [drive mode, tilt mode, seat elevator mode; (2) to place visual display within optimal visual field/pursuit [joystick on left side/display on right side] (3) to provide a clear visual-motor display for effective power chair control as per residual deficits associated with Esotropia
e.	* Battery, 22NF Gel	*to provide power for the power chair
f.	*Q-Logic Curtis Expandable Electronics; Harness for Expandable Electronics; Drive through joystick; 2 plus actuators; Harness for Multiplier	*All these electronic components work together to allow the power chair's microprocessor controller to drive the power chair, operate the power seat tilt and power seat elevator through the joystick in which two actuators are required.
g.	Swing Away Joystick Mount Curtis, Inline Left	to allow the joystick to retract to the left side of the power chair to provide access to ADL tasks while also allowing her to control the joystick inline with her shoulder girdle

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h.	Tru-Balance Power Tilt	(1) provide pressure relief since she is unable to adequately shift her weight off of her ischial tuberosities (2) reduce vertical/downward gravitational pressure into her spinal column due to risk of fixed scoliosis (3) provide intermittent use of gravity as per trunk hypotonia and weakness
i.	Bilateral Armpads, Gel, Black 10" desk length; Arm Trough/Gel ArmPad, Desk, Hardware	(1) provide weight bearing surface for her bilateral upper extremities and tray (2) provide wide armrest support in line with her shoulder girdle to defer lateral trunk leaning (3) to mount the armpads to the armrest mounting bracket and (4) will be able to be removed as needed; e.g., transfers
j.	5X8 Angle Adjustable Footplates with Bumpers	(1) provide adjustable weight bearing surface for her B LE postural stability and to compensate for tonal implications (2) provide shock-absorbing padding to reduce jolting
k.	Jay Configure Fit Custom Configured "I" Seat w/ 1.5" foam	(1) provide a supportive, linear, planar seating surface to inhibit posterior pelvic tilt/ sacral sitting while facilitating trunk/neck upright posture; and (2)"I" seat design is needed to accommodate lateral hip guides/pads and allow adjustability over time
l.	Single Pull ant Pelvic Support No Padded; 1.5	(1) provide pelvic stability and alignment between lateral pelvic pads (2) to use angle-of-pull to inhibit pelvic rotation (3) for safety
m.	Bilateral Lateral Pelvic/Thigh Supports 3"H x 9"L with mounting hardware	provide adequate pelvic alignment and address mild pelvic rotation and obliquity while inhibiting lateral trunk leaning and trunk rotation
n.	Bilateral ABS Shoe Holders	(1) provide proper foot and lower leg alignment (2) prevent injury due to spasticity patterns in lower extremities
o.	Jay Configure Fit Custom Configured "I" Back w/ 1.5" foam	(1) provide a supportive, linear, planar seating surface to inhibit posterior pelvic tilt/ sacral sitting while facilitating trunk/neck upright posture (2) provide "I" seat design is needed to accommodate lateral trunk guides/pads and allow adjustability over time
p.	Bilateral Thoracic Supports 5"H x 4.5" D w/ mounting brackets & Quick Adjust winter/summer (SA) swingaway hardware	(1) decrease lateral trunk leaning & loss of postural control (2) winter-summer hardware accommodates various clothing thicknesses while continuing to provide lateral trunk support due to limited trunk control, trunk hypotonia/weakness, & lateral trunk rotation (3) swing-away hardware is needed for transfers (4) to mount pads to hardware
q.	Headrest pad, 10" Plush/Lycra	(Current donated headrest mount hardware with base to be reused.) (1) to provide head support when tilted (2) to replace worn headrest cover and foam

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r.	Anterior Thoracic Support with Strap Guides	(1) provide intermittent anterior trunk support as per trunk hypotonia (2) to allow intermittent removal to enable active trunk extension and muscular control/strength (3) Strap positioners are necessary to maintain/align the position of superior straps over shoulders and provide appropriate angle of pull to support her upright position
s.	Hip Abductor Pad w/ mounting plate 3"H x 4"L, 1" cantilever with flip-down bracket and abductor cover	(1) assist in maintaining her pelvic and lower extremities' alignment as per pelvic rotation in conjunction with the lateral hip pads (2) mount the pads to abductor flip-down bracket; (3) provide adjustability over time
t.	Custom Left Pad for Rear of Pelvis with support mounting bracket	provide a left/rear pelvic pad to block pelvic rotation
u.	Polycarbonate Upper Extremity Support w/ bilateral turn-key hardware, custom stomach & joystick cutout, stomach stop set	(1) provide upper extremity weight bearing to attain/sustain upright postural stability (2) current tray will not fit on new power chair due to different armrest size/shape & tray dimensions (3) turn-key hardware attaches tray to armrests (4) custom stomach cutout will contour to trunk shape to allow weight bearing; (4) joystick cutout for joystick access
v.		
w.		
x.		
y.		
z.		
aa.		

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bb.		
cc.		
dd.		

I certify that I wrote this report and I am the Licensed Occupational and/or Physical Therapist identified below. I have included my credentials, affiliated agency, address, and contact information. My signature affirms that I personally wrote each section of this report, except where an asterisk is designated, based upon my own clinical knowledge, training and evaluation of the person's medical condition.

Name:	Sylvia Cain	Credentials:	OTR, ATP	CT License #:	2348
Agency:	Easter Seals of Wallingford				
Address L1:	Assistive Technology Program				
Address L2:	456 Main Street				
City:	Wallingford	State:	CT	Zip Code:	06492
Phone Number:	860-123-4567	Fax Number:	860-765-4321	Email Address:	scain@esw.org

Electronic Signature Agreement. By clicking "I agree" and electronically signing below, you certify that: (1) you and the agency/facility in which you are employed agree to follow and are in compliance with the Connecticut Department of Social Services *Conditions for DSS Acceptance of Electronic Signatures ("Electronic Signature Policy")* and (2) your electronic signature below complies with the Electronic Signature Policy. A handwritten signature is required for all other practitioners.

☑	Signature:	Digitally signed by Sylvia Cain, OTR, ATP DN: cn=Sylvia Cain, OTR, ATP, o=Easter Seals of Wallingford, ou=Assistive Technology Program, email=scain@esw@org, c=US Date: 2013.10.23 10:37:42 -04'00'	Date (mm/dd/yyyy):	10/23/13

Physician's Signature: By signing below, I have reviewed and concur with the above evaluation:

Physician Agency:	Pediatric Medicine Associates, Inc.; Connecticut Hospital
Physician NPI:	987654321

Electronic Signature Agreement. By clicking "I agree" and electronically signing below, you certify that: (1) you and the agency/facility in which you are employed agree to follow and are in compliance with the Connecticut Department of Social Services *Conditions for DSS Acceptance of Electronic Signatures ("Electronic Signature Policy")* and (2) your electronic signature below complies with the Electronic Signature Policy. A handwritten signature is required for all other practitioners.

☑	Signature:	Digitally signed by Kevin Greencrest, MD DN: cn=Kevin Greencrest, MD, o=Midstate Medical Center, ou=Pediatrics Medicine Associates, Inc, email=kgreencrest@hhchealth.org, c=US Date: 2013.10.23 10:35:04 -04'00'	Date (mm/dd/yyyy):	10/23/13